

REMARKS

Claims 1-4, 6-12, 14-23, 25-31, 33-40, 42-48, 50-51, 70-73, 75-79, 81-82 and 106 are pending in the application. Previous dependent claims 5, 24, 41, 74 and 107 have been cancelled by the present Amendment.

The term “line item” is defined in each of the independent claims as including at least the following pair of values: “(i) *an out-of-pocket cost parameter that corresponds to out-of-pocket costs paid by the employee for use of coverage provided under the benefit category* and (ii) *a corresponding benefit cost to the employee for purchasing the coverage under the benefit category.*” An example of the claimed “out-of-pocket cost parameter” included in the line item is a co-pay amount that an employee is required to pay each time he/she uses the coverage. An example of the claimed “benefit cost” included in the line item is a monthly cost to the employee for purchasing the coverage.

Each of the independent claims requires the *simultaneous* display of a plurality of “*different*” line items (as such term is defined above) associated with a benefit category to the employee on a user interface. In other words, for a given benefit category (e.g., physician care), the claims require the simultaneous display of *multiple different pairings* of “out-of-pocket cost” and “benefit cost” values (as such terms are defined in the claim). An example of this aspect of Applicant’s claims is shown in Fig. 22C of the Specification, a portion of which is reproduced below:

Physician Care is that care which is provided by your physician to whom you have been referred. This care is most frequently provided in a physicians' office.

choose from the following benefits		
your <u>network</u> benefit	monthly benefit cost	your choice
\$0.00 fixed copay	\$54.30	<input type="radio"/>
\$10.00 fixed copay	\$47.42	<input checked="" type="radio"/>
\$13.00 fixed copay	\$44.78	<input type="radio"/>

In the embodiment shown in Fig. 22C, three different line items are simultaneously displayed for the “physician care” benefit category. Each of the three line items includes a different out-of-pocket cost parameter (i.e., a “\$0.00 fixed copay”, “\$10.00 fixed copay” or “\$13.00 fixed copay”) corresponding to an out-of-pocket cost paid by the employee for use of the physician care coverage. In addition, each of the three line items includes a different corresponding benefit cost to the employee for purchasing the physician care coverage (i.e., a “\$54.30 monthly benefit cost”, “\$47.47 monthly benefit cost” or “\$44.78 monthly benefit cost”).

The simultaneous presentation of different value pairings (i.e., the different line items) to the employee allows the employee to better understand the tradeoffs associated with, e.g., different co-pay and monthly benefit cost options for a particular benefit category such as physician care. Once the employee has been presented with the different line items, the employee makes a purchase selection that corresponds to one of the options presented (e.g., the employee clicks on the “your choice” button in Fig. 22 corresponding to the line item desired by the employee). This aspect of the invention is

reflected in the following language from claim 1: "*receiving via the user interface a purchase selection from the employee corresponding to one of the plurality of different line items associated with the benefit category.*"

Turning now to the final rejection dated February 9, 2007 and the Advisory Action dated July 11, 2007, independent claims 1, 21, 40 and 70 stand rejected as anticipated by Wizig. The standard for anticipation is as follows:

"A claim is anticipated only if each and every element as set forth in the claim is found, either expressly or inherently described, in a single prior art reference." *Verdegaal Bros. v. Union Oil Co. of California*, 814 F.2d 628, 631, 2 USPQ2d 1051, 1053 (Fed. Cir. 1987). ... "The identical invention must be shown in as complete detail as is contained in the ... claim." *Richardson v. Suzuki Motor Co.*, 868 F.2d 1226, 1236, 9 USPQ2d 1913, 1920 (Fed. Cir. 1989). MPEP, §2131.

Wizig fails to anticipate claims 1, 21, 40 and 70, because Wizig fails to show the simultaneous displaying of a plurality of different line items associated with a benefit category to the employee on a user interface, wherein each of the different line items displayed on the interface includes "(i) *an out-of-pocket cost parameter that corresponds to out-of-pocket costs paid by the employee for use of coverage provided under the benefit category and (ii) a corresponding benefit cost to the employee for purchasing the coverage under the benefit category,*" as required by the claims. In reasoning that Wizig discloses these aspects of the claims, the Examiner has cited to Figures 33 and 53 of Wizig, which are reproduced below:

Below is the list of physicians, hospitals, and other healthcare providers that have been selected:

JENNY LEE JONES

PRIMARY CARE PHYSICIAN:	PATCH A. ADAMS, M.D.	<u>Co-payment</u> \$ 20.00
INPATIENT HOSPITAL:	GENERAL HOSPITAL	\$ 500.00
OBSTETRICIAN:	NONE	NOT APPLICABLE
GYNECOLOGIST (excludes Obstetrics):	JOHN ANDERSON, M.D.	\$ 20.00
CARDIOLOGIST:	MARISSA WIZIG, M.D.	\$ 20.00
DERMATOLOGIST:	JERALD SKLAR, M.D.	\$ 20.00
UROLOGIST:	NEAL MATHIEW, M.D.	\$ 20.00
EMERGENCY ROOM:	ST. ANYWHERE E.R.	\$ 20.00
PHARMACY:	DIANE'S DRUGS	\$ 20.00
DENTAL:	HAYLEY WIZIG, D.D.S.	\$ 20.00
VISION:	BETH OLIAK, M.D.	\$ 20.00
UMBRELLA POLICY:	TIFOSI LIFE CO	\$2,000.00

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FIG. 33

Please edit the following list of sponsored plan members:

Name of Plan Member	Sponsor Contribution	Sub-Sponsor or Employer ID Code	Sponsoree ID Code	Initial Sponsoree ID Password
JOHN MICHAEL JONES	\$ 5,000.00	Wizig&Company	3452112	abdfgi97
HAYLEY CLAIRE LYNN	\$ 5,000.00	Wizig&Company	3452122	bcdfigi97
MARISSA LYNN HOWARD	\$ 5,000.00	Wizig&Company	3452132	dhdfgi97

PREVIOUS

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FIG. 53

Significantly, Figs. 33 and 53 of Wizig are *not* displayed simultaneously. In addition, as Applicant emphasized during the interview, *neither* of these figures *individually* shows the *simultaneous* display of *multiple different pairings* of “out-of-pocket cost” and “benefit cost” values (as such terms are defined in Applicant’s claims) for a given benefit category. More specifically:

- The only values displayed in the interface of Fig. 33 of Wizig are “Co-payment” amounts. None of these “Co-payment” amounts correspond to a “*benefit cost to the employee for purchasing the coverage under the benefit category,*” as required by the pending claims. Rather, the amounts shown in Fig. 33 of Wizig merely correspond to costs associated with the use (rather than purchase) of coverage. Thus, Fig. 33 of Wizig clearly fails to meet the limitations of Applicant’s claims.
- The only values displayed in Fig. 53 of Wizig are “Sponsor Contribution” amounts available for purchase of benefits. None of these “Sponsor Contribution” amounts “*corresponds to out-of-pocket costs paid by the employee for use of coverage,*” as required by the pending claims. Rather, the amounts shown in Fig. 53 of Wizig correspond to contributions made towards the purchase (rather than use) of coverage. Thus, Fig. 53 of Wizig clearly fails to meet the limitations of Applicant’s claims.

Clearly, the rejection of claims 1, 21, 40 and 70 as anticipated by Wizig cannot be maintained, because Wizig fails to teach each and every element of these claims. In fact, as emphasized during the interview, the “default co-payment” functionality disclosed in col. 14, lines 26-37 of Wizig (which pre-selects a *single* default co-payment option for display) actually teaches away from the *simultaneous* display of *multiple different pairings* of “out-of-pocket cost” and “benefit cost” options for a benefit category, as required by the pending claims.

Independent claim 106 stands rejected as obvious over Wizig in view of Spurgeon. The standard for establishing a case of obviousness is as follows:

To establish *prima facie* obviousness of a claimed invention, all the claim limitations must be taught or suggested by the prior art. *In re Royka*, 490 F.2d 981, 180 USPQ 580 (CCPA 1974). “All words in a claim must be considered in judging the patentability of that claim against the prior art.” *In re Wilson*, 424 F.2d 1382, 1385, 165 USPQ 494, 496 (CCPA 1970). MPEP, Section 2143.03 (Emphasis added).

As was the case with claims 1, 21, 40 and 71, independent claim 106 requires the simultaneous display of multiple different pairings of “out-of-pocket cost” and “benefit cost” values (as such terms are defined in the claim) for a given benefit category. For the

reasons set forth above, it is clear that these aspects of claim 106 are not disclosed in Wizig. Nor are these aspects of claim 106 taught by Spurgeon. Thus, it is respectfully submitted that the Examiner has failed to establish a case of obviousness with respect to claim 106.

The Examiner has asserted that there is a lack of clarity with respect to “how the ‘plurality of line items’ is distinguished from benefit categories.” Applicant respectfully disagrees. As described above in connection with Figure 22C of the Specification, an example of a benefit category is “physician care.” In the example of Figure 22C, three line items (i.e., \$0.00 fixed copy/\$54.30 monthly benefit cost; \$10.00 fixed copy/\$47.47 monthly benefit cost \$13.00 fixed copy/\$44.78 monthly benefit cost) are associated with the physician care benefit category. Thus, there is a clear distinction between a benefit category and line items.

Finally, the Examiner has asserted that it is not clear how the terms benefit categor(ies), line item(s) and benefit type(s) relate to each other. Referring again to the example of Figure 22C, there are multiple benefit types shown on the left side of the diagram, including “health” and “dental.” The “health” benefit type shown includes a plurality of benefit categories, i.e., preventive care, physician care, emergency care, pharmacy care, alternative care, vision care, behavioral health services and personalized services. The “physician care” benefit category in turn includes a plurality of line items (i.e., \$0.00 fixed copy/\$54.30 monthly benefit cost; \$10.00 fixed copy/\$47.47 monthly benefit cost \$13.00 fixed copy/\$44.78 monthly benefit cost). Thus, there is a defined

hierarchical relationship among the “benefit type,” “benefit categories” and “line items” recited in the independent claims, i.e., a plurality of benefit categories are associated with a benefit type; and a plurality of line items are associated with a benefit category.

Response To Points Raised In Advisory Action

In the Advisory Action dated July 11, 2007, the Examiner has asserted that the Applicant’s definition of “line item” as recited in the pending claim lacks support in the originally filed disclosure, and based on this assertion, the Examiner has reasoned that she can ignore Applicant’s specific limitations defining “line item” in the claims in favor of the “broadest reasonable interpretation” of “line item.” With all due respect to the Examiner, this reasoning is flawed and must be withdrawn.

First, it is beyond dispute that Fig. 22C of the specification as originally filed provides clear support for the definition of “line item” recited in the independent claims. As described above, in Fig. 22C three different line items are simultaneously displayed for the “physician care” benefit category. Each of the three line items includes a different out-of-pocket cost parameter (i.e., a “\$0.00 fixed copay”, “\$10.00 fixed copay” or “\$13.00 fixed copay”) corresponding to an out-of-pocket cost paid by the employee for use of the physician care coverage. In addition, each of the three line items includes a different corresponding benefit cost to the employee for purchasing the physician care coverage (i.e., a “\$54.30 monthly benefit cost”, “\$47.47 monthly benefit cost” or “\$44.78 monthly benefit cost”). In view of Fig. 22C, the Examiner’s assertion that Applicant’s definition of “line item” lacks support in the specification fails as a matter of law. *See, e.g., Cooper Cameron Corp. Kvaerner Oilfield Products, Inc.*, 291 F. 3d 1317, 1322 (Fed. Cir.

2002)("Drawings constitute an adequate description is they describe what is claimed and convey to those of skill in the art that the patentee actually invented what is claimed"); *Wang Laboratories, Inc. v. Toshiba Corp.*, 993 F.2d 858, 866 (Fed. Cir. 1993)("[a] patent specification is directed to one of ordinary skill in the art" and that " 'drawings alone may provide a "written description" of an invention as required by §112'""); *see also* MPEP §2163.02 (Support "may be shown in a variety of ways including ... disclosure of drawings ... ").

Second, where, as here, an Applicant specifically defines a term (e.g., "line item") in the claim, the definition recited in the claim controls and cannot be ignored as the Examiner has done in this case. As set forth in MPEP 2111.01:

An applicant is entitled to be his or her own lexicographer and may rebut the presumption that claim terms are to be given their ordinary and customary meaning by clearly setting forth a definition of the term that is different from its ordinary and customary meaning(s). See *In re Paulsen*, 30 F.3d 1475, 1480, 31 USPQ2d 1671, 1674 (Fed. Cir. 1994) (inventor may define specific terms used to describe invention, but must do so "with reasonable clarity, deliberateness, and precision" and, if done, must "'set out his uncommon definition in some manner within the patent disclosure' so as to give one of ordinary skill in the art notice of the change" in meaning) (quoting *Intellicall, Inc. v. Phonometrics, Inc.*, 952 F.2d 1384, 1387-88, 21 USPQ2d 1383, 1386 (Fed. Cir. 1992)). Where an explicit definition is provided by the applicant for a term, that definition will control interpretation of the term as it is used in the claim. (Emphasis added).

Third, it is beyond question that the Examiner is required to address all of the limitations in Applicant's claims in any prior art rejection. Specifically, in comparing Applicant's claims to Wizig for purposes of assessing anticipation, it is impermissible for the Examiner to ignore the explicit limitations defining "line item" in the claims, i.e., the limitations requiring that a "line item" include at least the following pair of values: "(i) *an out-of-pocket cost parameter that corresponds to out-of-pocket costs paid by the*

*employee for use of coverage provided under the benefit category and (ii) a corresponding benefit cost to the employee for purchasing the coverage under the benefit category.” See, § MPEP 2131 (“A claim is anticipated only if **each and every** element as set forth in the claim is found, either expressly or inherently described, in a single prior art reference”); see also, MPEP § 2143.03 (“**All** words in a claim must be considered in judging the patentability of that claim against the prior art.”) With all due respect, the Examiner decision to ignore the explicit claim limitations defining “line item” in assessing anticipation constitutes legal error and should be withdrawn.*

Finally, the Examiner continues to assert that the language in previous claims 5 and 74 renders terms in the independent claims unclear. Claims 5 and 74 have been *cancelled* and are no longer pending. In view of the cancellation of these claims, it is beyond dispute that they cannot serve as a basis for asserting that terms in the pending independent claims are unclear.

Conclusion

In short, when *all* of the limitations of Applicant’s independent claims are properly considered – including the limitations defining “line item” in the claims -- it is beyond question that the rejection of claims 1, 21, 40 and 70 as anticipated by Wizig cannot be maintained.

In view of the foregoing amendments and remarks, it is respectfully submitted that all independent claims are allowable over the cited references. All dependent claims depend from an allowable base claim, and are therefore also allowable. A Notice of Allowance is earnestly solicited.

The Commissioner is hereby authorized to charge any fee due in connection with this filing, including any fees for extra claims, to Deposit Account 50-0310.

Respectfully submitted,

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